



TEXAS DEPARTMENT OF HEALTH  
BUREAU OF RADIATION CONTROL

Application for Adding Equipment to Mammography Certification

Complete all items of the application in accordance with Title 25 Texas Administrative Code (TAC) §289.230(t). Please print or type. ***The completed application, copy of the medical physicist report and a copy of the accreditation application must be sent prior to using the mammography equipment.*** Retain a copy of the application for your files. Submit all requested information to either address:

**Postal service address:**

Texas Department of Health  
Bureau of Radiation Control  
Mammography Certification Program  
1100 West 49<sup>th</sup> Street  
Austin, Texas 78756-3189

**Overnight/express service or personal delivery address:**

Texas Department of Health  
Bureau of Radiation Control-N127  
Mammography Certification Program  
8407 Wall Street  
Austin, Texas 78754

If there are any questions, contact the Bureau of Radiation Control at (512) 834-6688.

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**Section 1: General Information**

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State Mammography Certification No:     M00    

Legal Name of Facility: \_\_\_\_\_

DBA(if applicable): \_\_\_\_\_

Mailing Address:(Street/City/State/Zip)

Machine Use Location Address:(Street/City/State/Zip)  
(If multiple use locations, use additional sheets)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mammography Facility Phone Number: \_\_\_\_\_ FAX #: \_\_\_\_\_

Radiation Safety Officer: \_\_\_\_\_

Telephone #: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Lead Interpreting Physician: \_\_\_\_\_

Telephone #: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Contact Person & Title: \_\_\_\_\_

Telephone #: \_\_\_\_\_ E-mail address: \_\_\_\_\_

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## Section 2: Accreditation Status

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*If this application is for a breast biopsy unit, skip this section.*

1. With whom do you plan to accredit this machine: ☐ Texas ☐ American College of Radiology
2. If you answered **American College of Radiology**, you must submit a copy of the application submitted to ACR.
3. If you answered **Texas**, do you have other equipment accredited with ACR? ☐ Yes ☐ No
4. If you answered **Yes**, you must accredit this machine with ACR or choose to accredit all of your machines with Texas. If you choose Texas, you must request an accreditation application from Bureau of Radiation Control.
5. If you answered **No**, you must request an accreditation application from the Bureau of Radiation Control.

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## Section 3: Mammography Equipment

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*Complete this section for each mammographic x-ray unit. Check **all** appropriate boxes. Include a copy of a current medical physicist report for each machine. (Note - if there are any failures and/or deficiencies on the report, attach a list of corrective actions. Include copies of service/work invoices with the description of corrective actions.)*

☐ Located Onsite

*or*

☐ Mobile unit

Indicate which services this machine is used for, check all that apply:

☐ Mammography

☐ Breast Biopsy

1. Control Panel Manufacturer: \_\_\_\_\_ Control Panel Model Name & Number: \_\_\_\_\_ Control Panel Serial Number: \_\_\_\_\_
2. Target(s) & Filter(s) available: ☐ Mo/Mo ☐ Mo/Rh ☐ Rh/Rh  
☐ W/AI ☐ W/Mo ☐ W/Rh
3. Type of Imaging System: ☐ Screen/Film ☐ Digital  
Screen/Film Combination: Screen: \_\_\_\_\_ Film: \_\_\_\_\_
4. Analysis of Phantom Image: Phantom manufacturer and model number: \_\_\_\_\_  
Technique used for phantom: kVp \_\_\_\_\_ mAs \_\_\_\_\_ or mA \_\_\_\_\_ & time \_\_\_\_\_  
Mode used: ☐ AEC ☐ AOP ☐ Auto kVp ☐ Other \_\_\_\_\_

*Check all objects that are visualized on the phantom:*

Fibers: ☐ 1.56 millimeters  
☐ 1.12 millimeters  
☐ 0.89 millimeters  
☐ 0.75 millimeters  
☐ 0.54 millimeters  
☐ 0.40 millimeters

Must see entire fiber to count as a whole.

Specks: ☐ 0.54 millimeters  
☐ 0.40 millimeters  
☐ 0.32 millimeters  
☐ 0.24 millimeters  
☐ 0.16 millimeters

How many specks in last group? \_\_\_\_\_

Masses: ☐ 2.00 millimeters  
☐ 1.00 millimeters  
☐ 0.75 millimeters  
☐ 0.50 millimeters  
☐ 0.25 millimeters

Must see rounded shape to count as a whole.

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### Section 4: Mobile Services

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*If you checked mobile for any mammography equipment in Section 3, you will need to complete this section.*  
{ 25 TAC§289.230(1)(8) }

- " Main location where machine, records, etc. will maintained for inspection. This must be a street address, not a P.O. Box.

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Street

City

State

Zip

- " **Attach** a sketch or description of the normal configuration of the mammography unit's use including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed unit inside, furnish the floor plan indicating protective shielding and the operator's location.

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### Section 5: Certification

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I certify that all information submitted with this application is true and current to the best of my knowledge.

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\*Typed or printed name and title

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Date

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Signature

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Typed or printed name of person who completed application

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Date

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Signature

*\*This shall be the signature of the Administrator, President, Chief Executive Officer, Owner or Partner of the facility.*

As the **lead interpreting physician**, I do hereby affirm that I assume the responsibilities in 25TAC§289.230 (k)(1)(A) in association with this application.

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Typed or printed name of lead interpreting physician

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Date

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Signature

As **radiation safety officer** for this facility, I do hereby assume those duties and responsibilities as listed in 25 TAC 289.226(s)(2). I certify that all information submitted with this amendment is true and current to the best of my knowledge.

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Typed or printed name of radiation safety officer

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Date

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Signature